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THE FAMILY

Every science begins as philosophy and ends as art; it arises in hypothesis and flows into achievement. Philosophy . . . is the front trench in the siege of truth. Science is the captured territory; and behind it are those secure regions in which knowledge and art build our imperfect and marvelous world. Philosophy seems to stand still, perplexed; but only because she leaves the fruits of victory to her daughters, the sciences, and herself passes on, divinely discontent, to the uncertain and unexplored.

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THE RELATION OF PSYCHIATRY TO SOCIAL WORK[1]

JESSIE TAFT, PH.D.
Director, Child Study Dept., Children's Aid Society of Pennsylvania

IT is not often that one has the experience of witnessing the birth of an epoch-making movement. One hundred years from now the story of the beginnings of mental hygiene will be a vital chapter in the history of our culture.

Like the veteran of a great war, one cannot help feeling childishly important at possessing memories of leaders and critical events. Moreover, there is a fascinating illusion of power in looking back, panoramic fashion, over a bit of history with which one has been sufficiently intimate to be able to follow the pattern unguided. One's sense of belonging to the process and knowing its inner reality is so strong that one begins to feel creatively responsible.

Mr. Beers will forgive me if I begin with mental hygiene when I first knew it, some years after the founding of the first mental hygiene society, when it had begun to show the effect of the combined efforts of psychiatry and social work. At that time it was concerned chiefly with those larger social problems in which psychiatry and social work were equally interested—the after-care of the mentally ill, the out-patient mental clinic, the relation of mental defect to delinquency, and the allied problems of social hygiene, alcoholism, and syphilis. All the early activities centered about institutions, the psychopathic hospital, the hospital for the insane, the school for feebleminded, the prison, the reformatory, the court. This was the day of the eugenics field worker with her elaborate charts and her mass of unanalyzed, unassimilated facts, gathered in the hills and back-woods of Dutchess County or some other spot where Jukes and Kallikaks abounded, at great risk of limb and loss of shoe leather. She was perhaps a prehistoric form of what we now call the psychiatric social worker, although she seems to us to have had very little understanding either of psychiatry or social work.

The immediate ancestor of the psychiatric social worker is to be found in a small group of not more than half a dozen persons, among whom I have the honor to be numbered, who were sometimes called mental hygiene workers. They were located in Boston, New York, Baltimore, and Chicago. They worked under psychiatrists in the social supervision of clinic or hospital patients in the community. Miss Jarrett in Boston, Miss Tucker and myself in New York, Miss Thompson in Chicago, are the only ones I am sure of as existing in this dawning period of mental hygiene, but I doubt not there were one or two others.

[1] Given at the New York City Conference of Charities and Corrections, May 12, 1926.

There were at this time, about twelve years ago, only three or four centers where psychiatry and social work were undertaking a joint program. In Boston, Dr. E. E. Southard and Miss Mary Jarrett were engaged in a systematic attempt to relate the psychiatric and social factors in the preventive social treatment of borderline mental conditions and the after care of more serious cases. Here was built up the most technical, specialized social case work in connection with psychiatry that appears in this early period, the case work which was largely responsible for the birth of psychiatric social work.

In New York another emphasis was given to the mental hygiene movement by the very different psychiatric viewpoint which prevailed. Dr. Adolf Meyer and Dr. August Hoch, and later Dr. C. Macfie Campbell and Dr. Thomas Salmon, were among the first to offer vital interpretations of personality and behavior to those who were trying to solve social problems. The Mental Hygiene Committee of the State Charities Aid Association carried on its educational propaganda for mental hygiene, for parole and social service in state hospitals, and for adequate institutions, under the inspiration of this teaching. To Cornell Clinic of Psychopathology, where Dr. Hoch and his staff from the Psychiatric Institute were trying to treat patients in the light of their newer psychology and understanding of mental difficulties, this Committee contributed a social worker as demonstration of the value of social case work in a psychiatric clinic. Miss Katherine Tucker initiated this program and I was her successor in 1915.

It was inevitable, with the interest in psychological interpretation which animated this group of psychiatrists, that their peculiar contribution to social psychiatry should have been on the side of a dynamic interpretation of behavior, a method of approach to human beings, applicable to all case work and not confined to the development of a specialized form of social treatment for mental patients. They were interested in relating (rather than in separating normal and abnormal) and therefore conceived of mental health as the concern of every human being. If Boston set the pattern of psychiatric social work, New York put the stamp of its psychiatric thought upon the psychology which was to be the chief tool of the modern case worker.

From Washington were coming the publications of Dr. White which have so profoundly affected mental hygiene theory and practice; but so far as I know, there was never any overt combination with social work in that city.

In Chicago, Healy had begun as early as 1909 his investigation of the Individual Delinquent in connection with the Juvenile Court.

Dr. Bernard Glueck was already working within the prison walls to bring psychiatric understanding to bear upon the problems of criminology and there had been established at Bedford, under Katharine Bement Davis in 1913, one of the first well rounded attempts to study every aspect of delinquency. The Laboratory of Social Hygiene, as it was called, was a forerunner of the child guidance clinics in its insistence upon a well-rounded diagnostic study. The staff included a psychiatrist, a psychologist, a sociologist, and social workers, or field workers as they were first called. Its failure to develop was due to the failure of the reformatory situation to allow for treatment after diagnosis was complete.

Well do I remember the awe with which we gazed upon Hoch, Meyer, and Salmon when they appeared at Bedford for the first meeting of the Laboratory advisory board, and how we treasured every word of the discussion. Those of you who have always known a human psychology, who have been nurtured on our modern psychiatric viewpoint, will never know the thrill of the first mental hygiene pamphlets to one who had had only academic training. That plain little pamphlet of Hoch's on *The Manageable Causes of Insanity,* bringing mental disease into the realm of the knowable, was the key to an undiscovered country, a promised land indeed to some of us who had been groping in the dust of the academic desert.

Meyer's early paper with its involved title, suggesting the connection between unfavorable personality traits in early life and the later development of a psychosis, was another beacon light. You who are flooded with literature on every phase of mental health cannot imagine how we cherished those early papers. I can remember the first

time I ever heard Dr. Salmon speak; and what I carried away from that meeting, a commonplace in our teaching today, was the thrilling realization that every kind of behavior, no matter how bizarre, is an attempt at adjustment.

With those few but pregnant crumbs of a new psychology as a basis, I wrote my first speech on mental hygiene. It was a painful but profound experience. The result was long and labored, and quite unrelated to the needs of the audience, but it had the glow of a religious conversion and the audience responded sympathetically to the sincerity of my emotion.

If you would trace the growth of these beginnings, the gradual but steady deepening of the relation between psychiatry and social work, go to the reports of the National Conference of Social Work. You will be amazed to find how the focus of interest has shifted, how the terminology has changed, how the psychology of social case work has been transformed in the last ten years. In 1914, 1915 and 1916, there were sections on Defectives and The State Care of the Insane and Feebleminded. Mental hygiene was mentioned chiefly with regard to mental defect and there was a beginning of emphasis on prevention of mental disease. Alcoholism, drug addiction, syphilis, social hygiene, and delinquency were in the foreground of discussion. Dr. Healy appeared on a National Conference program in 1914 to tell about his work with young offenders. Meyer, Goddard, Davenport, and Southard appeared in 1915 to talk about the prevention of mental disease and defect and a program for state care.

It was not until 1917, when the Great War set the problem and the task, that there was such a thing as a Mental Hygiene section at the Conference. The problems of the war absorbed most of the attention of National Conferences for two years. The most significant result of this critical period for social case work was the opening of the first training course for psychiatric social work at Smith College in the summer of 1918. For the first time, thanks to the unwearied efforts of Miss Jarrett and Dr. Southard, psychiatry made a definite attempt to express its contribution to training in a systematic form.

Atlantic City in 1919 was a landslide for mental hygiene: the Conference was swept off its feet. In every section, psychiatrists appeared on the program. The psychiatric social worker was present in person for the first time and violent indeed was the discussion which raged about her devoted head —what should be her training, what her personality, and what the limitations of her province? Should she remain forever different from every other case worker or should every other case worker be reborn in her likeness? That was the meeting which burst its bounds and had to be transferred to a church a block away. Dignified psychiatrists and social workers climbed out of windows in order to make sure of a good seat. Was it the emotion engendered by the war, the brilliance of Atlantic City sunshine or a Boardwalk encounter with a great psychiatrist who dropped a word of encouragement which makes the Conference of 1919 so radiant in my memory?

Underneath the war fever and the excitement over the advent of the psychiatric social worker, a new note was sounded at Atlantic City, a note prophetic of the next step, the new focus of psychiatric and case work interest on the mental health of the child, the maladjusted school child, the delinquent child, the placed out child.

Most of us here tonight have no illusions as to the adequacy of our insight into the problems of children and the sureness of our skill in solving them, but I wonder how many of you have any conception of the depths of ignorance which prevailed in 1917, 1918 and 1919. The family case worker was aware of children in bunches; she seldom stopped to individualize. The children's worker was beginning to find social history very important but had little time to get acquainted with the child himself. The visiting teacher perhaps came the nearest to knowing what her young clients were like. As the case worker began to realize the presence of the psychiatrist and the mental clinic, and as the conviction of the importance of the child's personality grew, she hastened to present the problem child to the psychiatrist, who at that early period was about as much at a loss as she. Do you realize that there were hardly more than two psychiatrists in the country in 1917 who were familiar with children? As far as I

know, Campbell and Healy held undisputed possession of the field.

I can remember my own discovery of children, the thought of something young, unformed, unmarred, with whom mental health was as possible of attainment as physical health. What an escape from the intolerable situation of the adult with his fixed ideas and habits! Why spend one's life trying to make over a bad job when children are at hand to be guided into the kingdom of good adjustment? In the inspiration of this new and boundless horizon, I wrote my first paper about mental health for children. Again my own enthusiasm and the ignorance of the audience concealed successfully the pitiful lack of concrete content. Mr. Folks, who read the paper, remarked mildly that I had used a good many words. I knew he was right; I couldn't go behind those words and produce realities, but I felt sure the reality must be there if only I could get to it, and I made up my mind then and there never to give up until those empty words came alive.

By 1921 and 1922 it seemed as if the whole world had discovered children. The Milwaukee Conference, the Providence Conference brought out the visiting teacher movement and the school as a center where children must be reached in the interest of better adjustment.

By 1923, with the help of the Judge Baker Foundation, the newly organized Bureau of Children's Guidance, and all the rapidly forming child guidance clinics, we had begun to follow children back and back to the very moment of birth and were ready for the nursery school and the habit clinic.

So complete was our concentration on the individual child that it was a bit of a shock to find adult parents, also individuals, waiting at the end of the road, waiting to be recognized as the source of the child's habits, good and bad, and the hope of his future salvation. It was no accident that introduced the topic of Parent-Child Relationships in the Toronto Conference of 1924.

The hour of parent education has struck. Cleveland will see the first formal program devoted to the interests of the new movement. The circle is completed; the orphan child is dead, long live the child with two parents!

What is at the present moment and what is going to be in the future the relation of these two whose coming together we have reviewed—psychiatry and social case work? As I see it, they cannot get along without each other, for they are working on a common problem, with the same interest but with different techniques. Both are concerned with the rebuilding of the maladjusted personality and with the ultimate improvement of social adaptation. Psychiatry in the future as in the past will probably continue to be the source of the conscious psychology which the case worker uses. The case worker's task is too practical and her training too limited to make it at all likely that she will originate much of the psychological theory which she needs as a background for her work. With academic psychology on the other hand, useful as she finds psychometric tests, she has little in common. She must have the type of hypothesis which is built up in an attempt to treat, not merely to investigate, the personality and behavior difficulties of human beings.

The use she will make of the psychiatric point of view depends upon her training and her ability. She will never have the time or the preparation to encroach seriously on the personal analytic task of the psychiatrist nor will she ever seek to enter the diagnostic realm. With the exception of psychiatric social work, which technically comes under psychiatric direction, the relation of psychiatry to the great mass of case work will, as I see it, be more and more educational, more and more confined to the teaching of a growing point of view with direct assistance on only the most difficult cases.

One of the main objectives ahead is to provide in our schools of social work a training in case work theory and practice which is organically related to the psychiatric interpretation of behavior in every detail of social diagnosis and treatment.

What shall be the content of this psychiatric viewpoint, only the future will determine; but that it will broaden and deepen and take into account more and more the field of unconscious motivation there is no doubt. It is not for nothing that the word psycho-analytic appears boldly this year for the first time on a National Conference program.

Certainly among the centers of growth for psychiatry as well as case work the various forms of child guidance clinics which the Commonwealth Fund has established have proved to be fruitful ground. Through the training facilities and the intimate contact with psychiatry, the case worker has been equipped to carry on a form of social treatment with research value. She has been given not only a psychiatric viewpoint but time to see how it could be applied in terms of environmental adjustment with conditions as favorable as they ever are in this world. It is to these and similar nuclei, where intensive work is made possible, that case work looks for a still more conscious skill, a more objective statement of what particular steps in treatment produce particular results and why.

For psychiatry too these joint undertakings with case work and psychology have not been without their benefits. Children have become flesh and blood realities. The limitation of the personal interview with the child as an ultimate source of treatment and the necessity of bringing about definite and carefully foreseen and selected alterations in the environmental set-up if children are to be re-educated, have become ever more apparent. The day is fast approaching when no psychiatrist will recommend country placement or a good foster home and believe he has contributed anything to the welfare of the child or to the understanding of the worker. In fact, it is already evident that he cannot give a formula for environmental treatment as we once hoped but must stick to his own last and develop more consciously and technically the field of personal analytic treatment, as the case worker must make specific and controlled the details of her manipulation of the environment and their effect upon the adjustment of her client.

We who are interested in bringing under conscious control the mental health of children have much to learn from two comparatively unused sources: on the one hand the wealth of detailed knowledge and treatment technique which is being developed rapidly by the psycho-analytic movement, and on the other the experience of progressive schools in use of a rich environment to release the unconscious forces of childhood in creative expression.

For psychiatry, as for case work, the child is the future or, perhaps one might better say, the infant is the future; but that future and the hope of determining it, depend upon reaching his parents and his school.

SOCIAL EDUCATION THROUGH DISASTER RELIEF[1]

JAMES L. FIESER
Vice-Chairman, American National Red Cross

THE American National Red Cross reaches its majority this year: it received its charter from the Congress of the United States in 1905—just 21 years ago. In 1906, one domestic disaster—that at San Francisco—was dealt with. Last year—a typical one in the recent experience of the Red Cross in the field of disaster work—it rendered relief in 61 disasters in the United States alone. The growth of cities, increasing density of population, the march of industry, the encroachment of bridges and made land upon our inland rivers and streams, new fire hazards, absence of river control, and many other factors have played their part in spreading disaster hazard. Alongside this probable increase of risk we should, however, place an increased sense of social responsibility for the weaker members of society, whether this weakness is the result of individual or group shock.

Red Cross relief work today tries to use every skilled device of modern case work. It uses all the consultative services that may be brought to bear upon each family situation in the brief time available. While all work goes back to first principles and must be speedy, it is surprising how much may be

[1] Given at a luncheon meeting on "The Experience of the Red Cross and Family Societies in Disaster Work," Cleveland, May 31, 1926.

done in other directions. Interest is aroused in the minds of advisory committee members, merchants, teachers, ministers, and other leaders, which survives long after the disaster worker leaves the community. In the more important towns these leaders often realize the need for some permanent family relief agency in the community, feeling that this work, which was good for them during the disaster period itself, will be of permanent value.

Through trial and error in its relief operations—from the San Francisco earthquake, through the Cherry Mine disaster, at Omaha, in the Ohio Valley, at the Salem fire, in the Key West hurricane, in the floods of the Mississippi, the Missouri-Illinois-Indiana tornado, and the countless other disasters at home and abroad—there have been developed sound and far-reaching principles of technique in disaster relief encompassing every conceivable social problem. This accumulated experience has enabled the Red Cross to locate common denominators, shape its policies with new definiteness, revise its methods, unify its procedure, and promote better popular understanding of objectives with each passing year. Measured in time, the 20 years since 1906 constitute a brief period. In growth and progress, disaster relief work has moved forward with social work thinking itself.

Red Cross relief activities after the Missouri-Illinois-Indiana tornado of March, 1925, may be cited as typical of the extent and depth of a single operation. Many cities and towns and an immense rural section within these states were swept by the tornado. It stretched across an area 400 miles long, left tens of thousands temporarily impoverished, and involved medical care for 3,000 men, women, and children who were injured often many miles from modern medical and hospital resources. Two or three thousand farm houses were demolished. Farm buildings, fences, trees, live stock, feed crops and farm machinery (the heart of the earning power of the farmer) were destroyed. Over three million dollars were spent in relief on this one disaster.

In the emergency period, the primary considerations are speed and centralization of relief authority. Multiple activity of decentralized agencies and individuals, each with a different standard and method, leads only to confusion. A central Red Cross administrative office is at once set up. A citizens' advisory committee is created, with sub-committees on food, clothing, shelter, medical aid, finance, and transportation which ordinarily meet any situation in the emergency period. Many of our more important chapters now have an emergency committee set up and have registered names and addresses and telephone numbers with local authorities and others interested. The central administrative office endeavors to coordinate the various efforts already under way and plans early registration of the families affected—the foundation for the individual family relief work which is to follow. Organized family visitation by competent workers is set in motion at the earliest moment. Here, as in any other family work, we come to the foundation for later diagnosis and treatment, itemized losses, the way old problems have been affected and new ones created, family resources, liabilities and needs, and the family's own plan for the future.

Fourteen points are essential in the final disposition of any family problem. These are axiomatic with every Red Cross worker on a disaster and have been drilled into the minds of thousands of members of local Red Cross advisory committees in recent years. They are the key to the awards which the workers and the committees are to make: (1) Name; (2) Address; (3) Number in family; (4) Age of each; (5) Health; (6) Occupation and income; (7) Disaster losses; (8) Resources; (9) Liabilities; (10) Help already received; (11) References; (12) Family plan; (13) Special problems; (14) Worker's plan.[1]

Information on these points presupposes the best available personnel and direction, and a close relationship to the advisory committee and to the business set-up of the office, including the disbursing and accounting office. In disaster relief work the business side of the office must receive constant attention, since out of its detail arise many difficulties which the case worker must help to adjust. Here, as elsewhere, it is increasingly important that the case worker have

[1] Latest revision Disaster Handbook.

an understanding of ordinary business practices. As someone said, care in covering points on family information is as essential as it is to have all the braces and jacks well placed before attempting to lift a house or a sunken ship. If they are well placed, the whole structure will come up together and at about the same time. When that stage is reached the committee and the workers are busy working over-time, settling family situation after family situation, and before you know it the town is substantially rebuilt, the families looking forward again, the relief workers returned to their work, resolutions of appreciation adopted, and the advisory committee thanked and discharged.

The advisory committee starts out in a period of confusion. It is often created hurriedly. Its members are frequently without understanding of social work principles. They are selected because they are thoroughly representative of the community, are not themselves prospective beneficiaries, and because they have the confidence of the citizens generally. Such popular confidence in a local committee is important because inevitably the first stage of good will is followed by troubled days of doubt and criticism when people wonder if anything will be done after all. Some look upon the Red Cross as an insurance company which will replace losses: they will not understand why a neighbor with perhaps a lesser loss should have received an award of a given amount while they received nothing. Criticism usually arises because one person thinks he did not get enough or because he thinks someone else got too much. It is not at first understood that the determining factor is need, and that, if this were not the gage, those best able to re-establish themselves would often be helped disproportionately and others would have, as a permanent inheritance, an insuperable loss without relief sufficient to rehabilitate them.

The advisory committee carries the message of the relief program back into the organizations, churches, and business interests from which they come. The committee members speedily learn that your advice and that of the doctors and nurses is sound, and they understand and support you in drying up refugee camps, mass feeding stations, emergency hospitals, old clothes depots and other evidences of mass handling, and in the general restoration of the community life to normal proportions. They will themselves shortly explain that it is imperative that the families be treated on an individual basis as soon as possible. They, without exception, back you in your efforts against mass purchases of relief supplies and understand that it is infinitely better to make purchases wherever possible upon the individual basis, conceding to the wish of the beneficiaries as to the store from which the purchase is to be made. They fight to preserve the individuality of the family. They quickly understand that such a policy makes certain that the community life itself is rapidly restored to normal proportions and that the whole community benefits through the speedy re-establishment of normal trade channels. Through the members of this committee you have assurance that each relief policy will have sound support and explanation within the normal inner circles of the city, town or township. If necessary, they will wage aggressive debate with other fellowtownsmen. Committee members will stand pat on such principles as the protection of confidential individual records—of which perhaps they had never heard a month or two before. Their influence works in widening circles so that gradually hundreds of influential people are supporting their position.

In the Illinois-Missouri-Indiana emergency (as in the disaster at Lorain, Ohio, the previous year) the Red Cross found the "Rural Caravan" an effective means of restoring normal conditions to the farm and outlying districts. The caravan consisted of one or more skilled disaster relief workers, accompanied by a caravan of trucks manned by 40 or 50 workmen who carried their own tentage and mess outfits so that they could work wherever they were stationed as they crossed the country. They cleared debris from homeside, pasture lot, or field ready for plowing, put up wire fencing which had been damaged, and helped generally.

The advance man with the caravan met hundreds of farmers in desperate condition. He sat down with the farmer for a little friendly chat. In this way he invariably got the man's attention and together they mapped out the work which the caravan was to do on that farm when it reached that

neighborhood. A forward look was always involved in such questions as the following:

(1) Do you intend to rebuild your house where it stood before, or have you and your wife ever talked of some other preferred position if you had to build again?
(2) Since spring planting has not yet gotten heavily under way, which section do you want for a garden plot?
(3) Which acreage do you want for a pasture lot?
(4) Which field do you want to plow first?
(5) Do you go in heavily on poultry or dairying?
(6) What about your feed crops?

During the discussion they of course found much else to talk about: All the little problems of the family, past, present, and future, came in at this point. This interview also brought out the fact that the cattle, hogs, and poultry had been destroyed, and these mean much in the household economics of the family. The advance agent, therefore, registered with the administrative officer at relief headquarters the need for so many spring chicks, one or two cows (indicating the preferred breed), a combination utility wagon for farm use and trips to town, and wire fencing. He listed the minimum farm implements immediately necessary. He indicated whether the topography of the farm itself permitted the use of a tractor later on to help out with the plowing. The Red Cross worker had to know that the cattle had passed the tuberculin test, that they were not scrubs, that they were good milk producers. These and a thousand and one other pertinent considerations were brought to light. Farmers who had not heretofore given much thought to questions of this sort found their social status improved by increased income.

On this visit he also got basic information upon which the case worker could later build her facts for an award. Perhaps the farm was heavily encumbered. Perhaps the plan to send the oldest boy to agricultural school must now be delayed. It might even be apparent that the farm must be given up because of the heavy encumbrances. Here are new case work factors which will test the skill of the family relief worker.

In most instances there is a rural advisory committee. As in city work, all this case work method and the reasons for each step become the common property of the rural advisory committee which interlocks with the city committee, and indirectly it becomes the common property of the rural community itself. Here we have a far reaching educational factor. Rural disaster relief work has just commenced to open up in its social phases.

Under our Director of Disaster Relief in the Midwestern Area functioned our Director of Medical Relief. Public health nursing service, through skilled public health nurses, was set up at different points for the purpose of seeking out victims who had not yet come to the attention of the registrar. Where the wind swept almost everything clean the most serious dislocation affected the children. (This is often true in disaster areas.) The schools were destroyed. The houses were destroyed. I saw small children grubbing in the debris for little pieces of broken pottery, or salvaging torn and discolored copy books. Not a toy was left. As was pointed out by our Assistant Director of Relief, "We are just beginning to see that new psychological problems are produced by storms of this sort." Psychological problems among adults as well as children were presented and solutions were reached through the sympathetic interest of doctors, nurses, and case workers, whose joint effort goes far beyond the mere making of an allotment for new furniture, for repairs to a house, or for new implements with which to work. Educational opportunities were seized on such occasions as well as in such simple cases as furnishing cows and chicks for the farmer, and restocking the farm.

In this discussion little space has been given to elaboration upon specific family histories. I have not told of the growth of co-operative arrangements with other organizations and societies, such as the Illinois Children's Home and Aid Society which served so well in the care of orphan children. I have not told of the splendid co-operation with the offices of local and state boards of health, co-operation with such volunteer groups as the American Legion and with official groups represented by the offices of the city mayors and governors of states, with Chambers of Commerce and with civic clubs—Rotarians and Kiwanians. I have striven primarily to sketch some of the ramifications of social work in time of disaster, to ticket some of the problems, and point out some of the accomplishments.

There are many things which remain to be done: More thoroughgoing family relief work would be possible if we could secure greater stability of staff. Many of our workers do not serve for "the duration of the war," but are released to us by their agencies for a stated period of weeks or months. They must, therefore, drop their families suddenly and return to their home stations. Often a disaster-stricken family will have two or three case workers dealing with its problem within a period of six months. How can this problem be met? Notwithstanding these dislocations, the case work is surprisingly excellent. Someone has recently said that the technique of disaster work and the contribution it is making or has made to the family work field, especially through social education in unleavened areas, is one of the most notable recent contributions in social work in America. Does it teach us anything of value in connection with our work in the individualized disaster situations which are back of the family problems with which we deal every day in normal communities where we have stability of staff and established community interest?

Governor Donahey, of Ohio, in a letter to the Red Cross a few months ago said:

> The people of Ohio, remembering two recent disasters of magnitude, have everlasting love for the Red Cross. In each instance, the forces of the Red Cross were on the scene immediately, administering relief in their scientific and helpful way among people who stood helpless, awed, dazed and hopeless. The task of directing rehabilitation work in each case was undertaken without delay and in business-like, systematic, and efficient manner carried to successful completion. It requires experienced workers to take charge of situations arising from catastrophes. Nobody knows when or where the next emergency may arise but the civilized world knows the Red Cross stands ready for it.

In these brief sentences Governor Donahey outlines the popular acceptance and expectation of sound social work in disaster relief by the public itself. He pays tribute through the Red Cross to the great spirit of social advance for which this Conference and its members stand. He gives thanks to the skilled social worker everywhere for his or her contribution in time of disaster. We must not, however, feel too complacent about it. The end of accomplishment has not been reached. The constant challenge is for new methods and better devices, for sound family relief work and sound public understanding.

Looking back on our field of progress we are not unmindful of the part which leaders in our older and more seasoned and skilled family work societies and in social work generally have played in establishing first principles in disaster relief work. At one time disaster work could easily have degenerated into a consideration of mere creature needs. Relief work might easily have been limited to mass feeding, distribution of old clothes, and other unrefined and elementary emergency measures. Thanks to the leaders in family social work this primitive method was only to be the beginning and not the end. The accepted principles of family work have, therefore, become the basis of Red Cross practice with a flexibility determined only by considerations of time, staff, funds and difference in distress and type of applicant. Family societies have helped to create, maintain, and improve this position. This is a good time to acknowledge the Red Cross debt of gratitude to those men and women everywhere in this country and to their boards of directors who, often at sacrifice to their own societies, have given such generous support in personnel wherever the emergency required it. We may all take pride in this spirit and this record of accomplishment since, after all, the American Red Cross belongs to all of us.

MEXICANS IN CHICAGO

RUTH S. CAMBLON
Assistant District Superintendent, Chicago United Charities

OUR Mexican population is increasing rapidly. We are feeling their presence consciously within the Hull House neighborhood. During the fiscal year of 1925, 2.43 per cent of the total foreign-born "under-care" families of the United Charities of Chicago were Mexican, 61 per cent of whom lived in this neighborhood (the Mary Crane District). All of a group of sixty-five families known to a Spanish

speaking worker in this district have come to Chicago since 1919, and the majority since 1922. With the exception of a few families who came to Texas ten to fifteen years ago, they have entered the United States since 1920. Their paths of migration have been varied: twenty different states in the United States figured in the travels of families in this group before their arrival in Chicago. Nineteen states of Mexico have contributed to this Mexican population. The greatest number have come from Michoacan, Guanajuato and Jalisco, where wages paid to laborers are lower than in the border states. They are drawn here by demand of American industry for laborers.

Mr. A earned 75 centavos (37½ cents in American money) a day as a farm laborer in Michoacan. He has gone back and forth to his home in Mexico three times since 1922 when he first came to the states. The last trip, he brought his family with him, coming directly to Chicago. He was earning 40 cents an hour in an implement factory before he suffered an industrial accident. He receives compensation under our state compensation act.

The Mexican background is rich in beauty of natural surroundings and genial climate, in wealth of mineral and agricultural resources, and a heritage from a civilization which antedates the European. Talk to the Mexican of his country if you would reach his heart, because he has so recently left it and is more than likely dreaming of return.

Beals[1] estimates that 85 per cent of the present Mexican population are Indian or mixed with Indian blood, with Indian habits predominating.

Mr. V claims a pure Aztec lineage. For five generations there has never been a blemish on the body of any one of his ancestors. All of the grandfathers lived to between 90–100 years.

Mr. V was the liveried coachman to the mayor of Guadalajara before the Revolution of 1910. In addition to his low salary, he made fabulous sums from his avocation of bull-fighting, which he spent betting on game-cocks and drinking with his friends. The mayor lost his office and bull-fighting was not paying in 1914, when Mr. V went to Texas to find work.

His work in the United States has been track labor and unskilled factory jobs, interrupted by a summer in the beet fields. During periods of slack work, he poses for art classes, as he still wears his bull-fighter's braid, which adds to his picturesque appearance and is a financial asset. He has developed tuberculosis. Adjustment to life and customs here has been difficult for him. His wife and children still fear him at times, because his only means of showing his superiority is by domineering over them. His respect for authority and position, acquired by the Indian through generations of submission to the white man, are shown by his extreme courtesy and politeness, when he jumps to his feet and bows in formal but friendly salutation.

Modification of his habits has been a slow process. He has practically given up drinking. His wife, who has had more education and is more intelligent than he, is taking the lead more and more in the management of the home. The tears stream down his cheeks when he begs the visitor to secure a pass for him to return to Mexico, but he swells with pride when he hears of one of his children's accomplishment at school.

It is not thought by Beals[1] that the Aztecs have moulded the life of the people as a whole. The physical and mental characteristics of their descendents have been modified, their stamina destroyed, as is well exemplified by Mr. V. Other descendents of Indian forbears differ widely from the Aztec. Many are honest, gentle, industrious, self-abnegating and religious (another trait handed down from the Indian is mysticism). The majority of the group we know best in Chicago seem to have these characteristics. They accept their misfortunes sadly but quietly, with no show of resentment, working at whatever offers.

Mr. J and his family have oriental physical characteristics, often seen among the Mexican Indians: low stature, round flat heads, almond-shaped, glistening brown eyes, and a dark olive complexion Mr. J's ancestors have always lived in Michoacan, as far back as is known. Both husband and wife read and write Spanish intelligibly. Mrs. J attended school, while Mr. J learned to read, write, and figure through experience in selling the corn which he cultivated and the soap which he manufactured in the employ of a landowner and store-keeper in the village of his birth.

Their manners and soft, rhythmic speech show a quiet reserve and gentleness rarely met in any other groups. At each meeting they shake hands gravely. They never fail to say, "Good-morning, how are you today—and how is your family?" and at departure, "Good-bye; many thanks for your kind attentions; may you pass a very pleasant day."

It is as natural for the Mexican to be polite as it is for him to eat.

The J family came to Houston, Texas, in 1922 and Mr. J worked on the railroad tracks for two seasons. A labor contractor from a Michigan Sugar Beet Company provided the family with railroad passes to the beet fields, good for return before December, 1923. When the season in the beet fields ended, friends told of opportunities of work in Chicago, so instead of returning to Texas they came here. Mr. J found work as a track laborer. Three tiny dark rooms in the rear of a two-story, frame house near the tracks, abandoned by all except colored tenants, were found at a cheap rent. Benches, a table constructed of boxes,

[1] Carleton Beals: *Mexico, an Interpretation.*

bed springs set on boxes, and a tiny second hand stove comprised their furnishings. The cold weather came and Mr. J was laid off, along with other track laborers. Meagre savings were exhausted, summer clothing was inadequate, illness followed and one child died of pneumonia. Gladly would they have returned to sunny Michoacan at that time.

The following winter Mr. J dropped a railroad tie on his foot, a new baby arrived, and Mrs. J developed tuberculosis of the bone. Afflictions did not come singly. They remain faithful to their religion and accept their misfortunes with a sweet, gentle melancholy born of generations of hardships.

The J's experience is typical of the families contracted for labor in the beet fields and later attracted to the industrial centers of the north in winter in search of employment.

Struggle for freedom has played an important part in the life of the Mexican. Benito Juarez, who created the Mexican Constitution of 1857, when the church and state were separated, was a full blooded Zapotec Indian. He holds a place in the Mexican's heart that Lincoln has in that of the American. One of the oldest Mexican clubs and benefit societies in Chicago bears his name. Another leader and martyr dear to the Mexican is Francisco I. Madero, leader of the revolt of 1910.

Mr. F, father of one of our families, has served under many leaders, beginning with Madero. He was with Obregon when he lost his hand. Mr. F is a mystical, sincere, visionary type, a lover of poetry, and keenly sympathetic toward his fellowmen. He identified himself with whatever cause he thought represented the highest ideals of human liberty. It is hard to imagine his gentle spirit allied to war-making. Although he was willing to be shot in battle at any time, a philosopher and dreamer, he had an extreme fear of anaesthetic and the surgeon's knife. He was unable to do heavy labor and needed an operation badly due to overstrain on horseback during army service. He left Vera Cruz when it was taken over by the de la Huerta faction in 1923, because he was a strong sympathizer with the Obregon government. He returned to his native land shortly after the operation was performed and is now in the employ of the government in one of the customs houses on the border.

War and religion, two of their chief interests, are strangely intermingled. Mexico is a country of religious holidays and feast days. Every person celebrates his saint's day and it is more important than his birthday—of which he may not even know the date. The religious feast days of chief importance are St. John's day, Easter week, and December 12th, dedicated to Saint Guadalupe, the patron saint of Mexico. Boys and girls are named for her and the legend of her miraculous origin is sacred to the common people. Mrs. R thinks nothing of keeping her children home from school to attend church on this day—a universal holiday in Mexico. Almost every Mexican home here has its picture or image of Saint Guadalupe and the blessed Virgin Mary.

The M's are very proud of the large picture of St. Guadalupe which hangs above a rough wooden shelf on which candles and icons are placed in her honor. The walls of an otherwise dingy, unattractive living-room and bedroom combined, are decorated with small religious pictures arranged in patterns. In Mexico the M's always attended church on Sunday and worshipped on all saints days when church celebrations were held. Here they do not feel so close to the church and do not find it possible to attend so often, not only because our holidays do not coincide with the Mexican feast days, but because it is a distance to the church where services are held in Spanish.

Mr. M was a farm laborer in Michoacan, the place of his birth. His father owned a small piece of land near the village where they lived. He classifies ownership of land in Mexico under three headings: the haciendas which employ a great many laborers to raise cotton, sugar-cane, and coffee; the ranches, which are also extensive and where laborers are employed to care for animals and raise grain for feed; and more common, the small plot of ground located on the hillsides surrounding the village. These pieces of land are often cultivated by the owner but may be rented. The houses in the village are of cheap construction, sometimes only one room on the ground floor and poorly ventilated. The residents do not pay rent, even if they are not owners of the house, but are permitted to live there as caretakers. Pigs, chickens, and turkeys often occupy the same dwelling with the people. Every year the M's killed their own pigs for meat. The family did not maintain a butcher shop but sold meat to other villagers. They also raised corn and beans, chief articles of the Mexican diet.

Corn is soaked in lye water to remove the hulls, ground into a dough on a flat stone and patted in the palms into thin pan-cakes or "tortillas," which are roasted over the coals on a crude charcoal brazier, the only stove used in Mexico.

Mrs. G, whose husband's work is sometimes irregular, is able to economize here by grinding her corn for the cakes which they use in the place of bread. It is a back-breaking labor requiring much time and we rarely see it practiced in Chicago.

Although she uses prepared flour and roasts her "tortillas" on the gas plate, Mrs. H is typical of the Mexican Indian woman, with her hair parted in the middle and hanging in two braids.

I have rarely found that the families of Mexican laborers have brought any of the

characteristic Mexican hand work with them. When I inquire about the Indian blankets, pottery, drawn work, and featherwork, they wish to send immediately to Mexico for some to give to me. The manufacturers of these articles reside in their native villages and their art is handed down from generation to generation. They rarely move to another locality. A few of the Mexican women in Chicago do hemstitching and drawn work which they learned in school. They learn easily to operate machines in the bedding and rug factories where many of them work.

Singing is a universal form of recreation in Mexico. The verses are of the ballad type and the music, often in a minor key, has a strange, mystical quality. Their emotions are vividly expressed in song. But Mexican homes in Chicago do not seem to encourage this talent, for the Victrola, with popular American jazz music, is common. Social gatherings and clubs at the neighborhood settlements make good use of their musical talent; a club leader at Hull House has no trouble in entertaining her group when singing and dancing is introduced.

There is a migratory group which comes and goes.

A typical family group are the L's who took their savings from labor in the beet fields and mines of Colorado and purchased trucks to join a relative who had a position in a manufacturing concern in Chicago. Twenty people travelled in two trucks and a second hand Ford touring car. Their only possessions were bedding and clothing. One truck stopped for repairs at the side of the road just out of Omaha, the tail light out of order. In the darkness Mr. L was knocked from the truck and injured by a passing motorcycle, all were arrested and spent the night in the county jail. Mr. L, helpless, was taken to the County Hospital. His wife and babies came on with her parents, uncles, brothers and their families because there was no place for them to stay there. In Chicago the men realized a little money from the sale of their cars. A few cheap second hand articles of furniture were purchased. The twenty people, including five distinct families, moved into six small rooms, in a badly ventilated, delapidated two-story frame building near the tracks, where some beds had been left by former tenants. The men and women set out to find work. Mrs. L earned enough to pay her fare back to Omaha to bring her sick husband here to her family. Two new babies were born in the group—one belonging to the L's. They suffered many privations.

When we first visited it seemed as though there were children under foot and over head,—babies swinging in hammocks over the beds. There was scarcely room to pass between trunks and beds. The air was stifling. Mrs. L, although physically exhausted, was working. Mr. L, standing on one crutch, was minding the new baby by pushing the hammock above the bed with his other crutch. He and his wife and two older children occupied the three-quarter bed at night.

Although the other men of the family found work they were not contented to remain in Chicago where they feared to be laid off during the coming winter. In Colorado the company store would give them credit. By dividing the $15 rent between them and living on the cheapest of diets, they saved enough to pay their way back to Colorado. There was no place for the L's in this migratory life for Mr. L had developed a chronic infection in the injured leg and was still unfit for work.

Mrs. L now keeps a clean, comfortably furnished three-room flat and has part time work. Her baby is round and rosy under infant welfare supervision. She follows their directions carefully. Mr. L is under the doctor's care with a visiting nurse attending. He is also being taught to work with his hands. The oldest child has started to a pre-school kindergarten.

On January 1st another big family group—three brothers, wives, and children; mother, sister, her child, aunt, uncle, and his children, and another family not related, rolled in from northern Wyoming where the men had been laid off from work on the railroad tracks. No other kind of work was available. They accepted the offer of a friend with a big truck to bring them through to Chicago. Their only transportation expense was the cost of gasoline, which was divided. They moved into seven tiny, poorly ventilated rooms in the rear of an old wooden building in a neighborhood of colored residents. Some of the men found work on the tracks but exposure brought on illness and privation followed. Help of nurses and case workers came to the rescue.

One extremely cold day the H's came in from Kansas City. They had formerly lived in a box car. Mr. H borrowed a few dollars to buy some second hand furniture and they moved into a dilapidated old tenement house where the water supply had been cut off. One day he came to the office saying he had stayed home from work because his wife had been ill. She had not gone to the pre-natal clinic to which she had been directed. A free doctor's services were declined by Mr. H, saying she was better.

About a week later she came into the office with a new baby in her arms and her other children, little bundles of dirt and rags, at her heels. Mr. H had attended her when the child was born and she had a badly infected breast. Her husband had not come home the night before, whereat she was deeply grieved. However, he returned home the same day.

When we visited, the children were running around barefooted and dirty, apparently not minding the cold, but with noses running. The beds had never been set up; all slept huddled together in some old blankets and ragged clothing in the corner of a tiny dark room. A one-hole laundry stove served for cooking and heating. The coal which we had sent was dumped in the front room. Rehabilitation measures were planned with the neighborhood nurses, but the next time we called our little rabbits had moved away.

The Mexican lacks physical resistance. His inherited physique, his lack of health habits or scientific health standards, combined with his migratory life make him peculiarly susceptible to disease. The death rate in his own country is high. Here, illness, maternity, and death figure very frequently in the crises of his life, as shown by the few examples cited.

The infant death rate in Mexico is much higher than in communities of like size in the United States. Beals states that "only the most sturdy survive, for in the capital 40 per cent of the deaths are those of children under five years of age." Inherent lack of resistance, change of climate, exposure, lack of conveniences in the home, and ignorance of proper feeding—all contribute to the causes of death here. The infant welfare nurses say that many of the Mexican mothers respond singularly well to instruction once they have gained interest and confidence. Among those families who move frequently from place to place this is difficult to accomplish. The H's are a typical example.

Flandreau[2] says that practically all Mexican working people are married by the church and perhaps 50 per cent by the law of Mexico, as the law has not been strictly enforced in the past. Most of the marriages in the recently arrived Mexican group took place in Mexico.

Mr. V said, "If you were married by the law and not by the church in Mexico your parents refused to recognize you, so we got married both ways." A lengthy document from Mexico corroborates his statement. Mrs. R, a widow living in Chicago, was not so fortunate. Her sweetheart brought a missionary priest to the house and a fake ceremony was performed, both promising to unite by law later. When the new baby arrived the man had disappeared and the legal ceremony never took place.

The E's are only one of many other Mexican families within the group in Chicago who were married by the church in Mexico and not by the government. In cases of domestic difficulty the effects of this commonly accepted standard are noticeable.

Mr. and Mrs. E had a church wedding in Mexico and had lived together happily for sixteen years when their affections became estranged. Mrs. E went out frequently in taxis and bought expensive clothes and furniture on the installment plan. She also kept a roomer. Mr. E remonstrated, perhaps not entirely by the persuasive method since he claimed a husband's rights, and Mrs. E carried some bruises. One night while asleep in bed he was shot through the arm. The family broke up, the man willingly giving the mother custody of the six youngest children. She had neither means nor ability to provide for them. It seemed impossible to make the father assume the responsibility. The man's morale was broken and he lost his position. A missionary friend effected a reconciliation and they left for the beet fields for the summer. Fortunately circumstances brought them back and we have prevailed upon them to have a legal ceremony performed by their missionary friend.

Our contacts with Mexicans in Chicago bear out the studies of Mexicans in other communities. Demand for cheap labor in the cotton and sugar beet industries, railroads and mines has drawn them here, and lifting the immigration restriction has made it easy for them to go back and forth. Labor contractors pay their transportation from Texas and the border. Few if any of them have any intention of permanently uprooting themselves from their own country; citizenship in the United States is not common. The Mexican is patriotic and sensitive, with keen pride in the development of his country.

Unfamiliarity with the language and the standards of this country and the seasonal character of his work make him a serious problem to the community where he locates. He seldom becomes a definite part of the community life because of his short period of residence. When some crisis occurs in the family life which ties them to one place, as in the case of the L's where the man was hurt, with encouragement and stimulation the family's progress is marked; but failure to bring about effective results often occurs because the families have moved before a foot-hold has been gained and confidence established. Meagre household possessions, bad housing, crowded living conditions are the by-products of their migratory life. As long as industrial conditions contribute in bringing Mexican labor to this country, we shall be faced with these acute problems in increasing numbers. We should be aware of the possibilities for satisfactory life expression in this country, which can be brought about only through a basic understanding of their characteristics and attitudes in their own land.

[2] Charles Macomb Flandreau: *Viva Mexico.*

THE FAMILY

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EDITORIAL

TWENTY years after the San Francisco fire comes the terrific devastation of the Florida hurricane. Those twenty years have brought a continuous enrichment of method in meeting the needs of human beings, an enrichment which means better service and different kinds of service not only for the victims of unforeseen disaster but for the individuals and families whose plight is none the less real because it is less dramatic.

Ten years ago the Red Cross had approximately a hundred more or less embryo local chapters along the Atlantic seaboard, with a membership of not more than a hundred thousand, a general director and a small handful of clerks with six small district outposts each staffed with an executive and three or four clerks. Today its work is literally nationwide, with three thousand well organized chapters providing a Red Cross unit in practically every county in the United States, with a total adult membership of three million, and a junior membership of five and a half million.

Seven hundred and fifty of the more important chapters have paid secretaries—usually with additional workers in varying numbers. Five hundred and thirty-eight of these chapters are authorized to do work for civilian families as well as soldier work; more than two thousand other chapters limit their family work to soldiers' families. Six hundred chapters carry on a public health nursing program with one or more public health nurses employed. Many of these chapters also do nutrition work and carry on classes in home nursing and first aid.

Red Cross home service work has afforded an outlet for social work thinking in the rural field, thereby creating for itself a challenging problem in leadership. Seven years after the Armistice, we find that new vitality and new courage have taken the place of doubt and uncertainty. Increasingly there is a sense of direction in the development of the activities of the organization, and it would be difficult to separate from the multiplicity of factors just how much influence has come from the exigencies of disaster relief work itself.

Mr. Fieser has shown how work in disaster relief has taken to itself the skills of other forms of social work and has thereby become more effective. May it not also be true that those who have gone from other community agencies to serve during the emergency period of a disaster have carried back to their usual daily task not only the stimulus of new contacts but something of a fresh point of view as to what is and is not serviceable in case work technique?

THE sad news of the death of Miss Zilpha Smith of Boston on October 12th comes to us just as The Family goes to press. Miss Smith was the first secretary of the Boston Family Welfare Society, serving from 1879 to 1903. From 1904 to 1917 she was Associate Director of the Boston School of Social Work. She continued her keen and active interest in social work, particularly family case work, up to the time of her death. The deep sense of loss of those who knew her as a co-worker and an inspiring leader—always eager for new ideas, yet always keeping a clear vision of the task as a whole—we need not touch on here. In a later issue of The Family we hope to have the privilege of paying tribute to the part which Miss Smith played in the development of social work thinking in this country, a part which was not restricted to any single field of work or to any one place.

PSYCHOANALYTIC CONCEPTS IN MENTAL HYGIENE[1]

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SINCE it would be folly to attempt within the scope of a paper such as this to cover the whole field of psychoanalytic concepts in mental hygiene, I am going to ask the privilege of confining my remarks at this time to the field of mental hygiene embracing those early years of experience characterized as the childhood period. As we progress, however, it will become evident that the problems of which I speak contain the root processes and beginning deviations later evidenced in the adult neuroses and psychoses, as well as those multiple personality variations from the so-called patterns of normal emotional and social adaptation, categoried so habitually as delinquents, psychopaths, criminals and the like.

We have assumed as our task in this field of social psychiatric practice, the understanding of cause and effect relationships as they are reflected in the behavior of individuals. It is necessary to improve our treatment in the handling of problems of unadjustment, and to develop a sufficiently fine technique in these treatment processes to make possible a more complete understanding, not only of what the purpose of the behavior is for the individual, whether good or bad, moral or immoral, social or unsocial, but also to seek the causal roots of these purposive impulses. Since we look upon behavior as only a symptomatic response to the needs and strivings induced in the individual as a result of life experience, we must cease to treat behavior per se as the primary disease issue and look upon it as a concomitant symptom-complex, the effect rather than the cause, just as we now look upon the chills, fever, strawberry tongue, and skin eruption of scarlet fever as the outward manifestations of a specific and primary infection. To carry the scientific analogy still further, the knowledge and study of emotional and mental failures of adaptation will furnish us with just as specific tools for prevention of personality unadjustment as the refinement and use of the Dick test bids fair to assist us in the prevention and final elimination of the scourge of scarlet fever. The need for understanding the use of certain behavior patterns in the responses of the child and of the adult has led of necessity to a recognition of the psychological mechanisms utilized by the individual in the service of the economy of his personality. It is through the recognition of these recurring patterns of reaction and the use we make of them in interpreting behavior, even during childhood, that the analytic concepts have most conclusively effected and shaped the mental hygiene movement.

Professor Freud early discussed, in his interpretation of the findings in the study of adult neurotics, the mechanisms employed by the individuals through the unconscious utilization of which the patient sought a solution of his conflict with reality. These mechanisms of projection and introjection, which will be considered in more detail later, definitely furnish the patient with opportunities to express through his symptomatic behavior the feelings, desires, and strivings which are consciously unacceptable to him.

The purpose of the neurotic symptom-complex becomes evident then, when we realize that through the utilization of these patterns of introjection or projection the individual is permitted to express and satisfy the cravings and wishes which otherwise would be unacceptable to him and to society. The fact that the roots of these neurotic processes are found without exception in the childhood period has provoked workers in the field of childhood problems to use the wealth of knowledge furnished by Freud and his followers, and to work toward the development of a technique of understanding which will not only assist us in handling the problems of unadjustment as they arise in childhood but also to assist us in working out a program for the prevention of later breakdowns.

[1] Given at the National Conference of Social Work, Division on Mental Hygiene, Cleveland, May 31, 1926.

From the knowledge and experience furnished by these analytic contributions, I have developed during the past four years the "ego-libido method" as my students are prone to call it, a method of evaluation of experiences, emotional, physical, intellectual, and social, during the life contacts of the child. We have used this method for the past year or more at the Bureau of Children's Guidance in the study, diagnosis, and treatment of all of our cases. For those of you who have sat in upon our conference discussions, the approach will be familiar. This method of evaluation and interpretation is dependent on a knowledge of all the facts and experiences gleaned from our study of the individual through the social history survey of the environmental background, comprising the psychological study of the child himself, and the estimate of his intellectual equipment, with its abilities and disabilities; the physical examination, including not only an estimate of his organic structure and growth, but especially the glandular integration and function, as well as the careful noting of disease and operative experiences; and finally the gaging of the child's attitudes, biases, interests, and enthusiasms in relation to himself and his experiences.

It is impossible to give an adequate discussion and illustration of this method of study, diagnosis, and treatment at this time, as it would outreach the scope of this paper. I would like, however, to discuss it briefly, and in a forthcoming volume, *The Mechanisms of Human Behavior,* I trust that some of the discrepancies and inadequacies of the present presentation may be eliminated.

To facilitate your understanding, there may be some point in furnishing you with a working glossary of the classifications used. While I have purposely chosen simple and familiar terms of expression, the interpretative values need to be specifically noted. In the use of the term "positive," I give it the specific value of "satisfying," implying then that, if an experience is positive, it possesses emotional elements of satisfaction, that is to say, it is something to be desired. By "negative" is implied the opposite side of the picture from "positive"; in other words, if an experience is negative, it is unsatisfying; hence, relatively speaking, it tends to become undesired. By "constructive" I mean that the value of the constructive experience for the individual possesses, whether consciously recognized or unconsciously determined, a progressive or constructive growth opportunity leading toward integration and maturity. Bearing in mind that our ideal for growth represents the continuous progress toward stable adult integration, any experiences which tend to assist in this integrative process, whether conscious or unconscious, I consider in this thesis as constructive. The obverse of this, the destructive experiences, then become identified with those trends in the daily contacts which tend to interfere with progress and integration. Since nothing in the organic world remains fixed and static, if an experience does not tend to lead to a constructive growth process, it is bound to produce, relatively speaking, a destructive or disintegrating force, which interferes with the continuous growth of the organism. This fact is a biologically accepted one in terms of physical growth and structure and can be paralleled by the dynamic impulse in the personality structure toward constructive integration or the obverse destructive lack of integration, and finally toward disintegration.

To indicate briefly the basis upon which the interpretation of the child's patterns of response or symptomatic behavior is built, may I ask you to recall the early discussion of the so-called "Pleasure Principle," described by Professor Freud in his interpretation of certain of the underlying impulses which activate the life purpose of the individual from the time of birth, or even before birth. For if one recreates the picture of the intra-uterine period of life, we see the embryo during the stage of complete omnipotence, surrounded by the protective body of the mother, furnished through her circulation the warmth, the nutritional products, and oxygen components for organic growth and comfort without effort or struggle of any kind. A pattern as complete and pleasurable as this product of a sensory experience *in utero* must needs be recognized

as a strong determinant for future strivings. The reliability of this concept is illustrated all too frequently in the evidence furnished in the neurotic and psychotic regressions in which the behavior and emotional patterns of these diseases furnish evidence of a wish to recreate the comfort, satisfaction, and release from responsibility so characteristic of that early period of complete dependent omnipotence.

With this intra-uterine period as a universal beginning pattern, we are then led to conceive that every experience of the individual, from the time the life process begins, takes on a feeling value of one kind or another for the individual. To reduce these feeling reactions to simple terms, we are safe in concluding that every experience, either simple or complex, important or unimportant as it may seem, takes on either a pleasurable or unpleasurable tone. Relatively speaking, then, we can describe the reactions of an individual to any given experience as predominantly positive, or satisfying; or predominantly negative, and unsatisfying. Bearing in mind the original universal source of the pleasurable or satisfying experience, the intra-uterine, it is easy to see that all humans are prone to seek a constant repetition of experiences colored by these positive satisfactions through the recreation of the infantile destructive patterns. This is an important concept to gain, for through our ability to recognize the emotional or feeling values which an individual is prone to experience in the light of his personal life contacts, it is possible so to organize his program of daily experience, beginning with the first few weeks of life, that the feeling values he creates will be predominantly satisfying, though the emphasis is placed from the beginning through careful direction upon the constructive satisfactions rather than on the destructive ones.

This approach, you will see, is not new for the creation of healthy habit patterns in the early months and years has long been recognized as important. The contribution furnished by this method of evaluating each new experience in terms of the destructive or constructive elements is evident when one realizes the opportunities for creating in the daily program of the growing child healthy, satisfying, constructive growth privileges for the child, mentally, physically and emotionally. That is to say, if the daily experiences which are satisfying have a predominance of constructive rather than destructive elements, it is possible to wean the child from the tendency to recreate patterns of a destructive or regressive, satisfying nature, and to assist him in laying down habits which are constructive and which will lead him to establish patterns of response of a progressive and more integrated sort. This early integration holds opportunities for mental health and adult emotional maturity for the future. It will further be recognized that, relatively speaking, the usual response to the negative, unsatisfying contacts in one's experience would be undesired and unsought. The exception to this rule is found in children or adults who, when conditioned through repression and inhibition of the positive source of satisfaction, utilize this negative or unsatisfying approach as a compensation. This explains the frequent assertion that if the child can't get attention by being good (*i.e.*, in a way acceptable to society), he will frequently seek to get attention by using the opposite type of behavior, namely, by being bad.

In his original studies of adult neurotics, Professor Freud found a universal disposition of these "sick" individuals to recreate through the neurotic symptoms many of the infantile sources of pleasure, which in themselves during the early months and years of life are an accepted pattern of response in the baby. That these infantile values are not a part of the conscious adult experience will be evident to you all if you try the experiment of explaining to the neurotic person in simple language, understandable on his intellectual level, the real infantile source of his symptoms. Without any noteworthy exceptions, this adult person will respond to your intellectual ministrations by a violent denial of the reliability of your deductions. All too frequently the social worker or teacher who has gleaned a little insight into the source of neurotic patterns, in the over-enthusiasm inherent in the possessorship of a little knowledge, utilizes just this method of approach. The ineffectiveness of this procedure can only be adequately appreciated when we realize that the sole basis upon which neurotic and psychotic

symptoms are forthcoming is through the failure of the mechanisms of repression; that is to say, only through the medium of intense intrapsychic conflict of which the patient is not more than partially aware does the capacity for inhibition and suppression finally become overwhelmed, and the symptom-complex of the neurosis and psychosis begin to unfold; and all too frequently these changes in the personality occur without any conscious understanding, insight, or capacity for control on the part of the patient.

In the light of our knowledge that suppression and denial, with its concurrent conflict, is prone to produce only a disappearance of the tabooed wishes from conscious overt expression, whether the suppression or denial is derived from the personal conscience of the individual himself or from members of the social group, we see the destructiveness of repression in the pathological sense and come to realize even more forcibly the importance of the handling which the child receives in those early years. The relatively healthy and constructive experiences which come from normal, healthy parental relationships, where the emphasis and direction of the habit formation and early patterns are so well consolidated even in the first few months of life, as we have already noted, makes for a continuous progressive growth process of the child's personality and a continuous integration toward mature adulthood.

But all too frequently we find, in the study of these early years, evidences of unhealthy handling on the part of the adults who possess the right to wield authority over the child. The repressive, negative, unsatisfying, destructive patterns, which too frequently result from unwise oppression and authoritative control without the tempering of love and understanding, tend to produce the distorted experience of personality growth, so that the delinquent, neurotic, psychotic, criminals, and allied problems of unadjustment are made.

The fact that this is an indisputable truth makes it all the more urgent that we habituate ourselves to evaluate each new experience of the early years in the child's life to determine, in our plans for his training and education, whether each new contact and departure from the old scheme of things has a relatively constructive or destructive value for him.

In our attempts to shape his patterns of desire in these early months and years, we must know (as we have said before) whether the experiences, either constructive or destructive, possess a predominance of positive, satisfying qualities for him or whether these positive values are outweighed by too many negative ones. For we have already recognized the satisfying but destructive value for the individual contained in the impulse to seek a re-creation of the earliest experiences which contain the positive, pleasurable elements of infantile satisfaction. To reiterate, our plan for handling and treatment, either as a preventive or curative measure, must have satisfying, positive elements contained therein.

Since the original patterns of this regressive impulse are laid down in the biological anlage or structure of those intrauterine days, we can sense the dynamic force which underlies this pleasure-seeking pattern. This then should be our most effective guide in shaping treatment processes.

Our objective evaluation of the behavior of the child or adult in his blind search for pleasure will lead us to but one conclusion: that our job as social psychiatric workers and educators must be primarily directed toward the re-shaping and redirecting of this impulse to repeat for pleasure, so that the patterns of repetition are translated into terms of behavior which fall predominantly upon the progressive, constructive, although satisfying side of the picture. In order that we orient ourselves completely in the understanding of these dynamic impulses common to all humans, it is patent that a more specific method of evaluation of these satisfying and unsatisfying, constructive and destructive trends, must be made. Since we are concerning ourselves with the early beginnings of the life processes, it is but natural that our investigation should lead us back to the consideration of the two main streams of human activity, described in detail by many earlier writers but best evaluated by Professor Freud and his followers under the caption of the "sex" and "ego" instincts. For our purposes in the understanding of the life experiences of the child, it is easier

and will confuse us less if we think of the manifestations of the sex instinct as primarily of a love nature. For in all those first early years of a child's experience, any impulse of sex-like nature manifests itself in a dissociated and unconnected fashion apart from the function of reproduction, as has been indicated in our description of the omnipotence and satisfactions enjoyed in the intra-uterine period. The child not only brings to his first days and weeks of life a wish to be warmed and fed, but he responds with some show of satisfaction and pleasure to the loving care which is given him, even though his response of pleasure possesses no other outward manifestation of satisfaction than a snuggling down and a recreation of sleep. If we evaluate this reaction in the light of the positive satisfying patterns, we immediately assume that our method of treating him is pleasing to him and that his desire for comfort is unthwarted because of the love colorings which get injected into our relationship with him. That this is an important part of those early days and months is indicated by his irritation and displeasure when anything interferes with his continuous, comfortable program. For example, the irritation in waking, to find himself cold, wet, and hungry, he displays by uncontrolled crying if through the source of his parental attention his dissatisfaction is not immediately remedied. The possibilities of his irritation and negative feelings during these early months are manifold. The extent to which this pattern can unfold when a child has the early months complicated by physical irritations and handicaps, resulting from intestinal colic, middle ear infection, infectious disease, and so on, points to the degree of negative emphasis which can be created in the child's emotional patterns through this more or less chronic source of physical dissatisfaction. In the past, the emphasis of the parent and the nurse has been largely in the direction of the physical health and care of the child, and too little appreciation has been given to the emotional reactions. As we have already suggested, one source of dissatisfaction arises from within the child himself in response to pain and suffering; but, more important perhaps both from the negative and positive sources of the emotional patterns, are the kinds of attitudes and emotional values which are placed upon the care of the child during the infantile dependency period, during both normal healthy growth as well as during disease episodes, by the adult contacts.

As an index of how much even the health and life processes of the child seem dependent on the loving which it receives, are the figures of the high mortality rate among foundlings who are cared for in institutions and nursing homes where the hygienic equipment, scientific methods of feeding, isolation from infectious disease contacts, and careful medical and nursing care are given. Comparing the opportunities for physical healthiness and hygienic handling which these children get in comparison to those of children of the same age born in crowded, dirty, ill-ventilated homes, with no scientific methods of nursing, one would be likely to choose the former as an ideal kind of treatment experience for the baby. As a matter of fact the potentialities of continuous life and growth are much greater for the child in the dirty home. That this need for love seems to be the necessary constituent for the chemical processes of the life force would seem to be evident; and those highly trained, impersonal and scientific workers, who like to play with the idea that the future child will become the product of the scientific laboratory for child rearing, must needs, if they wish successful growth of the child to result from their experiment, perfect also a sympathetic love virus for daily injection. If one gets a reaction of wilting and dissatisfaction in the child torn loose from the parental love objects, it is not hard to imagine the relative possibilities for dissatisfaction which the unwanted child will find, even though he has the doubtful advantage of living in his family group. The multiplicity of the negative unsatisfying responses in the child's life experiences in such a setting can only be suggested. The refusal of the mother to render care when it interferes with her pleasure, the punishment and deprivation which the parents frequently perpetrate—not because the child deserves this treatment, but because his presence interferes with their program—would require, if the time permitted us to enlarge upon it by illustrations of actual case records, many hours for discussion. In this discussion one

chapter would be consumed in the enumeration of the possible destructive experiences which come to the children of intelligent and loving parents who delegate their children for care to the nurses, governesses, and hired helpers whose primary interest all too frequently is to keep the child quiet and make it presentable for inspection.

If space permitted it would be well to dwell upon the many other negative destructive possibilities on the love as well as the ego side of the child's experience; for such experiences as the loss of a parent, the coming of another brother or sister, the jealousy of the father, parental incompatibility and quarreling, the presence of unfriendly critical adults in the home, contacts with unsympathetic teachers, the lack of normal companionship and satisfying social contacts, the influence of physical handicaps and limitations, reactions to failure, problems of authoritative pressure, the strivings and repressions in response to problems of authority which become so frequently a part of the adolescent growth and desire for freedom—these experiences will suggest to you a few of the potential problems which need to be understood in order that future generations may profit by the failures of parents in the past in their methods of handling their children.

If the array of the negative, unsatisfying, destructive possibilities in the love and ego experiences of the child overwhelms us, a very brief survey of the potential, positive satisfying but destructive factors will provoke this question: with all the negative destructive opportunities on the one hand and the satisfying positive but destructive opportunities on the other, how does it happen that any of the human barques manage to steer their course between the Scylla and Charybdis of human experience to the harbor of so-called normality? The answer to this in our present stage of parental understanding would be, all too frequently, that it happened in spite of the parental handling rather than because of it. In passing, in order to orient ourselves, we should take note of such satisfying though destructive elements as too prolonged feeding, the use of the pacifier, permitting the child to sleep in the bed of the mother or to room with the parents, indulgence in special food whims, prolonged dependency with maternal attention, help in feeding and dressing beyond the early years, worry and anxiety of the mother which interferes with the normal kind of physical and social activity, withholding of outside contacts through the desire to retain the companionship and love of the child, resentment and jealousy toward the child's love, or friendly relations outside the family group, and a multitude of other possibilities which suggest the extent to which we need to know the intimate details of child-parent contact if we can hope to influence and shape the healthy, progressive trends of growth.

In the organization of a preventive and educational program for the parents and teachers who desire to furnish the child with opportunities for growth in a constructive, progressive fashion, emphasis must be laid upon creating possibilities for gaining the sense of security and satisfaction needed by the child in the early months, but with an eye toward weaning him in a way which is acceptable to him so that he may relinquish more specific infantile sources of pleasure and accept the satisfactions both on a love and ego level which make for progressive integration and moulding of a personality capable of meeting the issues of reality and gaining satisfaction from the challenges contained therein.

The schematic method which I have utilized in evaluating all the experiences which come to the individual is relatively simple. Under the two heads, libido and ego, are created four columns, two under the constructive, and two under the destructive caption. These two categories, under constructive and destructive, have been suggested earlier in the paper—positive or satisfying, and negative and unsatisfying. In considering the material available in any given case, it is a simple process to list briefly all the known experiences under the various headings, where they naturally fall, if you use the simple method of determining the value of any given experience for the individual in question.

The use of this method is readily acquired and actually need not require any undue amount of time if we habituate ourselves, as we study the case material, to organize our material to make these evalua-

tions. There is one precaution, however, which is important to bear in mind. That is that, having found this means of interpretation and evaluation to be successful in one case, we shall not deduct a priori that the same conclusions necessarily obtain in other cases which seem to be somewhat similar. This caution is not new to you, for the weak points in our treatment technique of the past have been profoundly emphasized by the tendency in most of us to make snap diagnoses of these situations. If we look upon each case as presenting us with an opportunity to discover a scientific plan for treatment through the study of cause and effect relationships within the experience of the individual—personal and environmental—then and not until then will the social worker have furthered her progress toward the refinement of a more effective tool of scientific study and treatment technique. If this method of approach is perfected, it may assist in preventing the human tendency to seek and wield the weapon of absolutism, as it is exemplified in our present day social concepts of right and wrong, moral and immoral, good and bad, in behavior. Most of us are comfortable and secure in our absolutism, like the Quaker of old, who remarked, "Everyone is queer but thee and me, and sometimes I think thee a little queer." Unless cautioned again and again it would be possible for those of you who choose to use this ego and libido scheme in interpreting the effect of any given experience upon the individual, to spend your life in an attempt to weigh in the balance, with hair splitting attempts at precision, each new episode in the life pattern of existence. To do this would involve you in such a mass of detail that you would soon lose the view of the forest for the trees. Therefore let us be satisfied with a simple, relative interpretation of the meaning of each new experience in the life of the growing child, noting only that, with few possible exceptions, every experience undoubtedly possesses some elements in its structure which will fall under both the caption of ego and libido values. Inasmuch as the differentiation between the ego and libidinal trends is not absolute, it is our task then to note in the main whether there is a predominance of ego or libidinal values and, if both trends stand out clearly, to evaluate them simply in the terms which have already been described to you at the beginning of the paper: namely, whether the feeling or emotional component involved in each new experience possesses an inherent constructive or destructive purpose, and if either constructive or destructive in its values, would it be more positive and satisfying or negative and unsatisfying to the individual? The importance of this understanding will become patent if we again capitulate that, in order to make possible the continuous progressive growth and integration of the personality, there must be a predominance of constructive satisfaction, both on the level of the ego and libido. In other words, to wean the growing child into relinquishing the infantile sources of satisfaction on both the love and self-evaluating sides of his personality, the growing-up process on the feeling or emotional level must contain positive values and satisfactions for him. An over-emphasis of the destructive infantile values, through the prolongation of the too highly charged and satisfying baby sources of comfort and pleasure, is bound to interfere with progressive growth, as will the predominance of negative unsatisfying denial of the infantile period tend to warp and interfere with progress.

If this instance seems too complex and unclear, perhaps the reconstruction of the more familiar ambivalency of human emotions as exemplified in the love-hate, pleasure-pain feelings will clarify my meaning for you. As a matter of fact, in the evaluating process, the simplest method to use in determining whether a given experience belongs on the constructive or destructive side of the page, is to ask the question of ourselves, will this experience, in the light of our knowledge of this individual and his life contacts, serve to assist him in reaching out for a constructive, progressive growth process, or will the emotional impulses derived from his experience have the opposite effect and produce in him a tendency to withdraw from growth and progress, and tend to create in him a desire to hang on to the infantile satisfactions on either or both the libido and ego levels of experience?

We have again come to recognize that the behavior manifestations of the individual are

but a symptomatic outcropping of the expression of his needs. The behavior of an individual then at any given point in his career is conceived as a definite response to the demands placed upon him through the medium of his biological, physical, intellectual, and emotional equipment, plus the sum of all his life experiences. This leads us to the necessity of evaluating his behavior reactions also, in exactly the same way as we do the environmental and experiential contacts. That is to say, we must determine whether his symptomatic responses are constructive or destructive and whether they are satisfying or unsatisfying to him. Here we come to the understanding of the "mechanisms of human behavior." In other words, through this evaluation we are able to interpret the purpose of a given behavior problem, whether good or bad, social or unsocial, in the economy of the given individual's experience, and we are led for the first time to a comprehensive interpretation of the purpose of the delinquent and criminalistic, asocial behavior of individuals, as well as the purposiveness of neurotic and psychotic reactions. Here again we utilize our understanding of the projective and introjective types of response mentioned earlier as a contribution of Professor Freud's. The introjective reactions which lead the individual to withdraw and turn in, in a subjective attempt to seek satisfaction and comfort, represent his solution to his problem.

We have already mentioned the fact that in childhood as well as in adulthood, the tendency to turn in or to regress toward the level of more complete infantile emotional satisfaction is present. This introjective process, the original satisfying pattern of which we have already suggested as being found in that comfortable dependency of the intra-uterine period, is a common experience for us all. In periods of illness we find it easy to sink or to regress to a dependency level. When a physical disease creates an excuse for care, it is simple for most of us to recreate, at least to a degree, some of the same satisfactions of emotional dependency and complacency which made up such a large part of our first relationship with the parent love-object in the early months.

Anything which threatens the individual's security—such as the loss of the mother love-object through illness, death, or at an earlier period the coming of a new brother or sister, if the child is unprepared for this new experience by a readiness to get positive satisfaction through more grown-up channels of expression—may produce a withdrawing from the more grown-up to the more familiar infantile levels of response.

This kind of reaction is illustrated by Jack, a manly little fellow of three and a half. From the age of two the boy had dressed himself, had fed himself and cared for his own toilet needs successfully. He was fearless, unafraid of the dark; he would complacently bid his mother good-night and would make no stir until morning.

Following the advent of the baby brother whose coming had been unheralded, he reacted first by an intense display of jealousy and a wish to shut the baby out of the picture. He asked each new and admiring visitor to take the baby home with her. When this method of disposal failed, he suddenly seemed to lose all his former ability to do things for himself. When dressing he would sit for hours with his shoe in his hand, asking that it be put on for him, and when told to do so for himself, his usual retort was "Jack can't, Jack is only a baby." Baby talk which had been relinquished early suddenly reappeared; he seemed unable to care for his own toilet needs, developed a series of food dislikes, demanded that he have a bottle like the baby because he couldn't drink from the cup and, as a final touch to this regressive introjective pattern, he developed night terrors, waking with loud screams, shaking with fear and wild with anxiety, the only solution for which was the coming of some member of the family, a substitute for the mother, to sleep in the room with him until morning.

In the light of our knowledge of the sequence of events, we see clearly the cause and effect relationship of the boy's behavior. Treatment of the symptoms by spanking or other authoritative handling, so frequently employed by parents in an attempt to create a more receptive attitude toward the new baby, would only suffice to make the rift between the child's love security of old and the relative insecurity of the present reality more painful; on the other hand, opportunities permitted by the parents to recreate the baby dependency again would have been destructive and regressive.

Only the evaluation of the purpose of this unconsciously determined behavior on the boy's part, and the knowledge of how one must recreate or preserve for him the security and positive satisfaction which he craves, at the same time that we create constructive opportunities for building a more grown-up relationship to reality, points

a solution for the problem. The child must be brought to accept the baby as his own, although he shares him with the mother and father. Through this kind of treatment, and this alone, can we hope to bring about in children a constructive disappearance of these unhealthy trends of jealousy and other destructive infantile regressions.

Relatively speaking, all degrees of intensity of reaction, from the simple temporary regressions of the moment, common to us all, to the more profound and devastating examples of regression such as are found in neuroses and psychoses of adulthood, are created by just such destructive patterns of positive and negative experiences during this early formative period. It might be well at this point, however, to caution against the use of too frequent generalizations. In actual practice one should evaluate each new experience of the individual and his reaction to it in the light of all that has gone before. It is an accepted fact that we meet the challenges of daily living, multiple as they are, primarily with the attitudes and emotional colorings which are consciously as well as unconsciously determined by the degree of healthy and unhealthy integration of our personality.

This explains how we can find such varied types of healthy and unhealthy behavior in the various members of a family group, in spite of the fact that essentially the same hereditary constituents have played their part in creating the original biological equipment of all the members of the family. The old time concept that every family must have its black sheep in the fold provokes a need for a new kind of interpretation of what constitutes the making of the black sheep, and all too frequently we find the explanation in the destructive emotional trends of the growing period of childhood handling, rather than in the accumulation of all the bad inheritance from both sides of the family reposited in this one ewe lamb.

This introjective type of response is perhaps better understood because of the contribution of the years of analytic study of the neuroses, and later of the psychoses; but the future progress of social psychiatric study of the opposite type of reaction, that is to say, the projective types of response, bids fair to add just as complete a chapter in our understanding of the overt explosive types of behavior, found in the asocial, predelinquent, delinquent and criminal careers, the roots of which are also found in the childhood period.

This projection type of response, the manifestations of which lead to a discharge of the irritations against the offending objects or their substitutes in the immediate or remote environment, is illustrated by the tantrum episodes of the child who is denied the piece of candy, the extra dessert, the additional chapters of the book, or the proverbial trip to the circus. The success of this method of getting what he wants when he wants it furnishes him with an effective weapon which he may retain through his whole existence. The fact that age may foster discretion in his use of this weapon may lead to the shading of the tantrum into a mood, but this is no reason for losing sight of the original purposive value or its root processes in childhood.

For in the adolescent or post adolescent, as well as the adult years, evidences of projective behavior are not wanting. The man who reacts to his wife's irritability at the breakfast table by grouching the entire morning at the office, the boss who takes the head off his office boy because his opponent wins the golf tournament, the boy who reacts to a cranky teacher or demotion in school by truancy, the child who is exposed to too oppressive discipline and authority and who reacts by running away—these represent the utilization of the same type of mechanism for solution of the problem just as, broadly speaking, the bolshevik who blows up the employer's shop or the desperado who seeks his satisfactions by heading the best organized gang in the country.

It is of course necessary to paint this picture of the mechanisms of projection and introjection in a most sketchy fashion because of the pressure of time, and for the same reason it is possible only to indicate briefly the diagnostic division of mechanisms included under these two big main groups of projection and introjection. In the diagnostic division of the mechanisms under each of the two main groups there would again seem to be a value in utilizing a descriptive terminology. Dr. Adolph Meyer first emphasized the value of a descriptive diagnostic

scheme in social psychiatric practice. If we again recount our theory of causality, we can only use this diagnostic method on cases where sufficient study has been made of the cause and effect relationships in the whole of the life experience of the individual and his reactions to these life contacts in terms of behavior. Our task is to determine what purpose, in his scheme of living, the particular, recurrent patterns of behavior have for the individual. Thus it will be seen that, when we tentatively divide the introjective type of response into groups such as the protective, substitutive, compensatory, and defensive mechanisms, we are describing *purpose* and *use* in one. The same also can be said of the use of such categorical divisions under the projective type of behavior. More consideration is needed at this point to interpret the diagnostic use of these mechanisms. This aspect of the method will be covered in the volume above mentioned. The most important contribution will be furnished through the suggestions for preventive and remedial measures contained within the "Purposive Diagnosis."

The inherent value of such a diagnostic scheme will be apparent if we compare the possibilities of treatment planning, in these cases where we have established a knowledge of the cause and effect elements and evaluated them as already suggested, with the old time method of diagnosis of "a neurotic child," "psychopathic personality," "constitutional inferiority" and "moral imbecile." By this means not only are we able to see the purpose of the behavior for the individual, but also at the same time our knowledge of the genesis of the habitual response of the individual leads us to appreciate that his attitudes, biases, beliefs, and feelings—and the externalized responses to these in the reality of daily existence—are but the products of growth and personality development whether we consider them healthy or unhealthy. It is within this field of better understanding that the possibilities for a new and refined technique in social psychiatric treatment lie. For if we have established the roots and causal beginnings back in the early period of the life of the individual, we will realize the folly of our former attempts to change attitudes by the mere contact of a social agency or doctor with the client, in which we were prone all too frequently to use persuasive discussion, authoritative pressure, cajoling, and the like, to gain our objective. We will also appreciate the ineffectiveness of trying to persuade a patient suffering from an obsession with the fear of cancer or syphilis, who has visited every diagnostic clinic in the city with negative reports each time, to believe that the doctors are right in their diagnosis and that the patient is wrong. For we must see that an obsessive belief of this calibre, with the intense anxiety which colors it, is only a symptomatic response to a deeper and more potent force than that which we can muster even though we become a constant attendant to the individual and concentrate our efforts on the so-called intensive case work treatment. Treatment processes must take into consideration the factors which determine the behavior, and then we will save ourselves time and unnecessary effort in trying to treat symptoms, for the limited success in the treatment of symptoms always reminds me of the task that the little boy assumed in attempting to stop the leak in the dyke with his thumb. It is too tiresome and hopeless a picture to perpetuate.

In the handling of individuals, the fact that it is possible to create in our relationship with our patients a kind of positive feeling which leads them to be willing to follow our advice needs also to be understood in the simple analytic terminology of positive transference. Social workers, teachers, ministers, and physicians would do well to gain a clearer understanding of this phenomenon. Psychological interpretation of this so-called transference phenomenon indicates that through the medium of the positive feeling that the patient develops, there is a recreation to a degree at least of the sense of security and emotional dependency of the childhood period. As long as the worker or psychiatrist furnishes additional opportunities for this kind of unproductive and unprogressive satisfaction, the patient will remain receptive. Unless then the worker or physician learns to use this positive transference as a medium through which constructive progressive opportunities are gained, and emancipation from the physician or worker (as the parent) is made possible, the results of treatment will be

limited. If time permitted, further discussion of this would be profitable.

To attempt to cover the subject of psychoanalytic contribution to mental hygiene adequately in the scope of a paper such as this is more than difficult, but one thought comes through crystal clear in concluding: that it is through the contribution of the psychoanalytic school to mental hygiene that the understanding of the root beginnings and processes of the neuroses, psychoses, delinquency, criminal careers and other problems of unadjustment has been made. The orientation which this knowledge furnishes us offers for the future in the handling of the child opportunities not only for the diminution in the incidence of the neurotic and psychotic cases but for the control and prevention of behavior and delinquent disorders as well. If we could take flight into the future we might discover that if as much progress is made within the next thirty years, or perhaps the next thirty times thirty, as has been made since Freud's first contribution to our understanding of these problems, mental illness as a disease entity will fast become as obsolete as yellow fever in Panama.

INSURANCE IN 250 UNADJUSTED FAMILIES

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IT IS becoming a serious problem for the welfare agency to know what policy should be adopted toward the unadjusted family with insurance. In the first place, this question of policy involves an analysis of the value of insurance in specific cases of dependency, since insurance is supposed to be protection against certain types of dependency. In the second place, if the welfare agency decides to carry the insurance of an insured, dependent family, in reality it is helping the family to save and this additional burden on the agency's funds not only requires the fixation of limits of insurance per family but also raises the question whether it should insure an uninsured, dependent family which comes to its attention. Otherwise, the latter family will be penalized in comparison with the former. In this connection the problem of insurance in unadjusted families is reduced to the original question of the value of insurance for dependent families.

Purpose of the Study

The type of insurance carried by families with small incomes furnishes protection against a single casualty, death; there is rarely provision for other emergencies, such as illness and accident, and no protection against unemployment, which are frequent causes of dependency. The intent of this study is to analyze this kind of insurance in cases of family dependency to discover if the protection afforded merits the cost to the family or to the welfare agency. While it would be highly desirable, as a preface to a study of this nature, to distinguish a normal rate of insurance for different income groups so as to furnish some measurement of over-insurance in dependent cases, it is scarcely possible to obtain such an index by the comparison of the insurance in self-supporting with economically dependent families. For this reason a statement of the facts concerning insurance in the 250 families will be presented prior to an evaluation of the service of insurance to dependent families.

This study includes a selected group of families for the purpose of analyzing the relation of dependency and insurance protection. The majority of the cases are recent, being on the active records of the Providence Family Welfare Society between the years 1920 and 1926, and the financial estimates with few exceptions were computed according to the 1925 price level. In the 250 families there are 1,521 persons with 1,207 insurance policies.

From the study of the insurance carried by 250 unadjusted families the following are the general results:

1. Average size of family—6.1 persons
2. Average number of policies per family—4.8 policies
3. Per cent of weekly income spent for insurance—5.7%
4. Average weekly income—$20.06
5. Average weekly expenditure per family for insurance—$1.14
6. Average weekly cost per policy—$.236.

Causes of Dependency in Insured Families

In the problem of insurance, as well as in the general treatment of dependency, the attitude of the welfare agency depends largely on the immediate factors which oblige the family to appeal for aid. These factors are revealed, of course, by means of the case analysis. Though actual cause and effect relationships are difficult to establish in many cases of family unadjustment, the major conditions leading to the appeal for aid are readily isolated. The following major causes were responsible for the dependency of the 250 insured families:

	Number of Families	*Per cent*
(1) Illness	75	30.0%
(2) Unemployment	57	22.8%
(3) Widowhood	33	13.2%
(4) Alcoholism	23	9.2%
(5) Desertion and non-support	18	7.2%
(6) Incompetency	16	6.4%
(7) Insanity	11	4.4%
(8) Accident	7	2.8%
(9) Divorce	7	2.8%
(10) Imprisonment of wage-earner	3	1.2%

Illness and unemployment, which top the list, are responsible for the majority (52.8%) of the dependencies. Dependency through widowhood, despite the invariable insurance of the father, accounts for 13.2% of the families and gives one index of the value of insurance for the financial independence of the family. The remaining families were reported for alcoholism, desertion, incompetency, insanity, accident, divorce, and imprisonment and include 34% of the families. All the conditions of unadjustment are self-explanatory except incompetency, which includes families that ordinarily earn enough to be self-supporting but which are handicapped by old debts, by the death of the mother leaving young children with the widower, by failure in business, by illegitimacy, by an income that is temporarily inadequate, or by mental defect other than insanity. While no judgment concerning insurance in families that are unadjusted for any of these reasons can be formulated prior to an analysis of all the factors involved in each family, taking the whole group as a unit, expenditures for insurance by families that are dependent for reasons other than illness or insanity (that is, in 164 families or 65.6% of the total studied) deserve careful comparison with other items in the budget; and in families dependent for these two reasons insurance on persons who are well is a possible source of extravagant outlay.

Like other expenditures of the dependent family, there is no valid reason why the welfare agency should not feel at liberty to reconsider completely a family's insurance in order to determine whether it is an asset or a liability. If the family is only temporarily unadjusted, or if the major problem is essentially social rather than economic, the question of insurance is generally of minor consequence. But when a family is financially dependent and threatens to become an allowance family or when a family has a record of periodical dependency, a complete appraisal of the family's income and expenditures, including the character of the insurance and the proportion of income spent for insurance, may be necessary in order to formulate a plan by which the family can be restored to financial independence. As will be considered more fully later, insurance in families of this type is death insurance (or, more aptly, "burial insurance"); there is rarely provision for disability benefits which would cover some of the conditions suggested above. In fact, disability benefits from previous savings through insurance were found in only one of the 250 families. Since the insured family is already dependent and the possible benefits of its insurance are only remotely connected with the immediate problem of restoring the family to self-support, the problem of the welfare agency in dealing with such families is practically reduced to the question of the present value of the dollar which is spent for insurance compared with the future benefits of insurance, and the present value of the dollar distributed among the other items of the budget.

Income of Insured Dependent Families

For the entire group, the average weekly income was $20.06. Thirteen families, at the time when their dependency came to the attention of the agency, had no income, and 43 families had a weekly income of less than $15, making a total of 56 or 22.4% of the 250 families that were practically allowance families. Of the total families, 123 or 49.2% received less than the average income of the group and 72 or 28.8% received more than the average income; 55 or 22% of the

families were earning approximately the average of the group. A scattering of families with an income above $35 per week were generally clients of the welfare agency for non-financial reasons (incompetency) and consequently their economic status and proportion of insurance require different treatment than would be prescribed for the economically unadjusted family.

Proportion of Income Spent for Insurance

The average proportion of income spent by this group for insurance was 5.7% or $1.14 weekly. Of the 250 families, 114 or 45.6% were spending less than the average, 43 or 17.2% were spending the average, and 93 or 37.2% were spending an amount in excess of this proportion. This average may serve tentatively as one indication of overinsurance. Certainly the problem of insurance in families that are not spending more than the average is less serious than in the family which is spending more than this amount. In the latter instance the high proportion of income spent for insurance deserves immediate and thorough study. Since the insurance under consideration seldom covers any other condition leading to dependency than death and since the family is already dependent, even a minimum expenditure for insurance is apt to encroach on immediate needs and be a burden rather than an asset. A reduction in the amount of insurance could hardly threaten the security of such families, and it is very probable that the concentration of expenditures on certain types of policies or on fewer policies might be socially valuable. Comparison with the expenditures for insurance by self-supporting families might furnish another check on the proper limits of insurance. Costs of insurance, economy of payments, the protection afforded, and the utility of insurance as savings are factors that must be considered more fully in each case of insured, dependent families.

Problem Cases With Insurance

Tabulating the facts concerning insurance in these families shows the essential problems encountered by the welfare agency in cases of dependency with insurance. It merges in the group and consequently hides several types of dependent families that have the most serious insurance problems. A brief review of some of these cases is necessary to give a valid account of a social worker's load, especially as it bears on problems of this kind. Summarizing the entire group with respect to insurance, the average expenditure for insurance (5.7%) indicates that these dependent families, in comparison with self-supporting families, have more than the ordinary amount of insurance. From the facts that are available on the subject of insurance any random sample of 250 families would not show as high a proportion of insurance. But this is a highly selected group, though the principal basis of selection is dependency and not insurance. It is only possible to conjecture the reasons for this overinsurance, but with this aspect of the problem the present study is not concerned. However, among the 250 families certain instances of insurance deviated so far from the average even of this dependent group that they are worthy of some consideration.

Illness and consequently irregular work caused family A, consisting of 9 people, to request aid from the Family Welfare Society in 1924. From this time they have continuously received aid. Their weekly budget, as estimated by the visiting housekeeper, is $37.49, their average income is $20.25. Despite this weekly deficit of $17.24, they are attempting to carry 29 insurance policies at a weekly expenditure of $4.34, which is 21.4% of their income and 11.6% of their budget. Either amount is prohibitively high for any self-supporting family. This case is a classical example of overinsurance. A reduction of insurance on this family is an economic necessity with few or no social consequences involved. However, the family objects to this; they are saving for the future.

The B's, a family of five, have been clients of the Family Welfare Society since 1921. Illness has prevented the husband from earning more than an average of $21 per week, which is inadequate. This family has a total of 13 insurance policies, 11 of which cost $2.85 weekly for a total sum of $3,002 worth of insurance protection. This is an exorbitant rate, but since there are many policies and weekly payments, no better rate can probably be given by any company under present competitive conditions. In addition the family pays 25 cents per week for a policy on a near relative (the mother being the beneficiary) which was taken out when the person was 57 years old, making a total weekly expenditure of $3.10 or 14.8% of their weekly income for insurance. The other policy was property insurance and falls outside the scope of this study. The B's illustrate not only an excessive rate of insurance but "burial insurance" at its worst.

Family C, a widower with five children, came to the attention of the society in 1923, when the man wanted to place his children in an institution temporarily. This is an instance of incompetency, since the man was earning regularly $35 per week and was able to support his family. This family's

expenditure for insurance is $6 weekly and constitutes 17.1% of their income. From the standpoint of constructive family case work the family has no economic problem and consequently the expenditure for insurance is purely a matter of interest to the individual.

Family D, which has been dependent for nearly two years, because the father is ill, presents the following problem: For the three people in this family the minimum budget required for their support was estimated at $22.96. When the man was able to work, his weekly wages averaged $12.66. Of this income $4 per week was spent for 13 insurance policies which is 31.6% of their income and 17.4% of their budget. Since insurance of this kind carries no disability benefits, a weekly expenditure of this proportion must necessarily encroach on other items of the budget, aggravating rather than relieving the dependency.

From 1918 to 1925 the E's, a family of ten people, were dependent on the Family Welfare Society for financial aid, because the father was alcoholic and worked irregularly. In 1925 the average weekly income was $17 and their budget was $29.93. This was obviously an allowance family with a weekly deficit of $12.93. During the period of dependency the family supported 12 different policies, paying $1.75 each week or 10.3% of their earned income and, judged by their budget, slightly more (6%) than the average spent for insurance by the entire group (5.7%). The wisdom of this expenditure may be rightfully questioned. At any rate a weekly expenditure of $1.75 for a total protection of $1,946 can be characterized in no other way than exorbitant. For such families insurance of this type is a singular luxury. In this and the other families just mentioned it is hardly necessary to point out that insurance benefits, even if they were received, would not affect the conditions of unadjustment to any appreciable extent.

Insurance as a Service

What function does insurance play in making family life more secure? When does insurance become a burden? Both these questions are intimately connected with each other and with the purpose of this investigation. Statistical and case analyses of these dependent families demonstrate the need for objective answers. Practically all authorities on budget-making regard insurance or some form of savings as a necessary item, but it is impossible to state outright what proportion of the income should be expended for insurance or savings and it is probably undesirable, since the expenditure, like other items of the budget, will always depend on other than purely financial considerations. Insurance and savings will vary in general with income, the number of persons in the family and the ages of these persons. Within these limits expenditures for insurance by self-supporting families can be gaged fairly accurately. But when the family is not self-supporting temporarily or intermittently, the problem of insurance protection is complicated by present needs both of the family and the welfare agency.

Nesbitt says, in discussing dependent families: "In most families, some form of insurance—which may be saving—against illness, death or other misfortune, is necessary to give freedom from pressing anxiety. Whatever seems necessary in individual cases should be allowed in calculating the budget";[1] and with reference to self-supporting families: "In a family containing children a normal standard of living should include savings or insurance which, in case of death or incapacity of the wage earner, will make it possible for the family to live until the children reach maturity without the mother being overtaxed or the children neglected. If the $10 per month suggested in the estimate below[2] is invested in insurance while the insured is in the early twenties it will buy a life policy of $5,000 or $7,500. An ex-service man of 26 years may buy for this amount a life policy of $7,500 which in case of his death or incapacity will be paid either in a lump sum or made to yield 240 monthly payments of $43.125 each."[3] In the first standard budget prepared for the Bureau of Labor Statistics essentially the same type of life insurance was advocated, though after 1914 the amount advised for safety ranged between $7,500 and $10,000.[4] Gibbs in agreeing with this attitude says, "The New York Association for Improving the Condition of the Poor advocates insurance only for the breadwinner."[5] Apparently there is no indication that insurance is an unnecessary item despite the financial status of the family.

Granted that insurance or savings is a necessity for the self-supporting family, does the same rule hold for dependent families? Is protection through insurance for such families more or less necessary to maintain

[1] F. Nesbitt: *The Chicago Standard Budget for Dependent Families.* Chicago Council of Social Agencies, p. 7.
[2] Ibid., p. 45, $154.85 per month without rent.
[3] Ibid., p. 43.
[4] Bureau of Applied Economics: *Standards of Living.* Bulletin Number 7 (1920), pp. 23–24.
[5] W. S. Gibbs: *The Minimum Cost of Living,* p. 28.

stability? Intelligent action by the welfare agency in this problem requires careful analysis of several conditions: namely, what is the character of the dependency? Is insurance or savings related in any respect to the rehabilitation of the family? When, if ever, does insurance cease to be a necessity and become a luxury? When is a family overinsured? What type of insurance is best adapted to meet the needs of families which are financially unadjusted? These and other questions are continually rising in the everyday tasks of the family case worker and are intimately tied up with a solution of insurance problems.

Studies of the amount of income spent for insurance by self-supporting families which are representative of many diverse social and economic conditions give the following proportions: Of the families classified in the $1,000 income group, which represents the average income of the 250 unadjusted families, colored farm families spent 3% for insurance[6]; white farm families spent 1.7%[6]; unskilled laborers in New York City (1917) spent 2.3%[7]; Gibbs estimated 1.3% for workers in New York City[8]; and the New York workers studied by Chapin in 1909 spent 2.5%[9]. Judged by these standards the average expenditure for insurance by these dependent families (5.7%) is approximately twice as great as self-supporting families are able to set aside for this purpose. This comparison indicates tentatively at least a considerable amount of overinsurance among these families, approaching an average expenditure seldom found in higher income groups. Clearly the sole defense for this expenditure rests on the assumption that for these dependent families insurance is the only feasible method of saving. Compared with expenditures for insurance and savings by self-supporting families, the proportion of income set aside by these dependent families for insurance corresponds very closely with the total for insurance and savings suggested by the budget of $1,476 compiled by Dr. Peixotto in 1917 for unskilled, self-supporting families (5.6% for insurance and savings).[10] It indicates that insurance does serve in general as a substitute for savings. In other words, these families, which are continually exposed to sudden emergencies not involving death, have no available resources to tide them over a period of financial need, because all their savings take the form of insurance. This attitude toward insurance as a form of savings may have serious consequences in individual cases as the steady flow of insured, dependent families to the welfare agency reveals. Insurance, therefore, as a partial or complete substitute for savings or as an expedient method of saving requires careful study, particularly from the standpoint of the cause of the dependency and the cost and compensation of insurance contrasted with the cost and value of savings.

Concerning the ability of the type of family under discussion to support the insurance suggested by these authorities, Chapin's analysis of insurance in 1909 holds pretty well today with slight variations in the amounts mentioned: "The insurance on the lives of persons is for the most part of the 'industrial type'; that is, for a weekly payment of a fixed sum—10 to 25 cents in most cases—an amount, determined by the age of the insured, is paid to the family after death. The amount of the policy is usually about $100 for adults and $50 for children. The money received from the insurance company usually goes to pay the funeral expenses attendant on the death, so that it is more properly described as burial insurance than as life insurance. A limited number of families, as will be seen later (p. 233), do carry a real life or endowment policy of $500 or even more. Some 56 cases are reported among the 318 families under consideration. In general, however, the insurance is not a provision for a rainy day, but a provision for meeting a single contingent expense; viz., the cost of burying the dead."[11] In other words insurance that can be afforded by those families, though a moderate or excessive proportion of the income, is "burial insurance." As a form of savings against dependency it is of practically negligible value. So far as protection beyond the burial of the dead is concerned, there is

[6] T. S. McMahon: *Social and Economic Standards of Living.* Appendix 1, Table 3.

[7] Bureau of Applied Economics, op. cit., pp. 102–108.

[8] W. S. Gibbs: op. cit., p. 14.

[9] R. C. Chapin: *Standard of Living,* p. 70, Table 15.

[10] Bureau of Applied Economics, op. cit., pp. 115–117.

[11] R. C. Chapin, op. cit., pp. 191–192.